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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00716

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

724

Item 7 File #G238 1-28-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Hebron		c. LENGTH OF STAY IN 1b 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Hebron		d. STREET ADDRESS Mt. Hebron		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH		First W.	Middle ALLEN	4. DATE OF DEATH January 20, 1959	Month Doy Year
3. NAME OF DECEASED (Type or print) JOSEPH		5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. ?		17. INFORMANT H. J. Baker, Ellicott City, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Apoplectic Hemorrhage of Left Cerebellar Hemisphere 331X				Address	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Alpha, Md	(County) Alpha (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>William V. Lovitt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/20/59	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1-22-59	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS West Liberty	22d. LOCATION (City, town, or county) Alpha, Md	(State) Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JAN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

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FOR STATE
HEALTH DEPT.

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13

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood		b. COUNTY Howard				
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glenwood				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First ELIZABETH	Middle ANN			
4. DATE OF DEATH		Month Jan. 20	Day 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1953			
9. AGE (In years at time of death) 5 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland				
12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME John Cotton		14. MOTHER'S MAIDEN NAME Marion Hoglund				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None				
17. INFORMANT John Cotton, Glenwood, Md		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cremation <input checked="" type="checkbox"/> in burning house DUE TO 916.0 Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dwelling burned to ground						
20c. TIME OF INJURY Hour 1.45 AM Month, Day, Year 1-20-59		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Glenwood	(County) Howard	(State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	George E. Burgtoft			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 1-20-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 1-21-59	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park	22d. LOCATION (City, town, or county) Baltimore, Md			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS	24a. REC'D BY REGISTRAR JAN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	
DATE			DATE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11,12 Film G238 2-2-59 et

80718

CERTIFICATE OF DEATH

Reg. Dist. No.

726

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Schaeffer Retreat		d. STREET ADDRESS 8636 Old Harford Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mrs. Mary R. V.	First Middle Last	4. DATE OF DEATH Dailey	Month January Day 21st Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 13, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David Myers		14. MOTHER'S MAIDEN NAME Margaret Taaband	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Anna Dailey, 2815 Rueckert Avenue Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH acute	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Coronary Occlusion Generalized Arteriosclerosis ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1</u> , 1958, to <u>Jan 1, 21</u> , 1959, that I last saw the deceased alive on <u>Jan 19</u> , 1959, and that death occurred at <u>8 5/4 M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>John A. Kochman</u> M.D. ADDRESS (Street, city or town, state) Dr. L. A. Kochman		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/59	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR JAN 28 '59	24b. REGISTRAR'S SIGNATURE John S. Hines
ADDRESS		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		727 HOWARD		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b instant.		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
rural - Clarksville						X Clarksville			
3. NAME OF DECEASED (Type or print)		First Dorothy		Middle Virginia		Last ESTEP		4. DATE OF DEATH Month January Day 2 Year 1959	
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1914		9. AGE (in years last birthday) 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house maid		10b. KIND OF BUSINESS OR INDUSTRY private home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank Thomas Wilson		14. MOTHER'S MAIDEN NAME Laura Rebecca Henson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215305230		17. INFORMANT Jesse Wilson, Highland, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Severe crushing injury to chest (auto acc.) instant.							
823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased driving car skidded on ice and ran into tree. Steering wheel crushed chest.		20c. TIME OF INJURY Month, Day, Year 8:45 a.m. 1-2- 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Road		20f. (City or town) Clarksville, Howard, Md.			
						(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Whitaker, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED January 2, 1958			
22a. BURIAL, CREMATION, REMOVAL (specify) Burial		22b. DATE THEREOF 1/6/59		22c. NAME OF CEMETERY OR CREMATORIAL Hopkins Church,		22d. LOCATION (City, town, or county) Highland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodgrass		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF HEALTH—ENVIRONMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2/15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3, 13 & 14, Film G-232 1/16/59.cac
 CERTIFICATE OF DEATH

00720

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Thunder Hill		d. STREET ADDRESS Thunder Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Anna Mae ANNE H. GOLDSMITH		First	Middle	Last	4. DATE OF DEATH Jan. 9, 1959	Month	Day	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 10, 1925	9. AGE (In years lost birthday) 33 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Unknown Amoss W. Herrmann		14. MOTHER'S MAIDEN NAME Unknown Margaret ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT C. Oliver Goldsmith, Ellicott City, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) METASTATIC BRAIN CANCER DUE TO (c) CANCER OF BREAST						INTERVAL BETWEEN ONSET AND DEATH 74 HRS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from 1-8, 1959, to 1-9, 1959, that I last saw the deceased alive on 1-8, 1959, and that death occurred at 2:00 PM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED 1-9-59-
ACTUAL SIGNATURE PETER V. THORPE			M.D.					
PHYSICIAN'S NAME (Type) PETER V. THORPE MD					ELLIOTT CITY, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-12-59	22c. NAME OF CEMETERY OR CREMATORIUM St. Louis		22d. LOCATION (City, town, or county) Clarksville, Md		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR JAN 12 59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

WISCONSIN STATE DEPARTMENT OF HEALTH—REGISTRATION

CERTIFICATE OF DEATH

REGISTRATION

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00721

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

729

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Highland				Highland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				
						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
JOHN ANDREW HOLLAND					Jan. 29, 1959			19
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
Male		Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 12, 1896	yrs.			Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Farm Laborer				Highland, Md				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
Grafton Holland				Elizabeth White				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		215-32-1270		Laura Wilson, Highland, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Epilepticus due to Cerebral Arterio- Acute								
334 X DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
sclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
22. ACTUAL SIGNATURE Donald E. Fisher, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED								
EXAMINER'S NAME (Type) Donald E. Fisher ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/2/59	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hopkins church, Highland, Md.	22d. LOCATION (City, town, or county), (State) Highland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Durden	24a. REC'D BY REGISTRAR FEB 3 '59	24b. REGISTRAR'S SIGNATURE C. L. Kraus						

WISCONSIN STATE DEPARTMENT OF HEALTH - SEAHOMER, JR.
MEDICAL EXAMINER CERTIFICATE OF DEATH

STATE
WISCONSIN

— — 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elbridge</i>		c. LENGTH OF STAY IN 1b <i>3 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1808 Montgomery Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FRANKLIN HENRY JONES</i>		4. DATE OF DEATH <i>Jan 20 1959</i>	5. SEX <i>Male</i>
6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 22, 1874</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Conductor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired. Penn. R.R.</i>	11. BIRTHPLACE (State or foreign country) <i>Indiana</i>
13. FATHER'S NAME <i>Jones</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Russell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>no.</i>	17. INFORMANT Address <i>Mr Charles H. Steele. Same</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Myocardial infarction, 3 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>Chronic myocarditis</i>			
C. DUE TO <i>General arteriosclerosis 3 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5609 Main St</i>
20f. (City or town) <i>Elbridge</i>		(County) <i>27 mg</i>	
(State) <i>Ind.</i>			
21. I certify that I attended the deceased from <i>Jan 16, 1959</i> to <i>Jan 20, 1959</i> that I last saw the deceased alive on <i>Jan 20, 1959</i> , and that death occurred at <i>4:18 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Brumbaugh, M.D.</i>			
ADDRESS (Street, city or town, state) <i>5609 Main St</i>			
DATE SIGNED <i>1/21/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 23, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mossberg Cemetery</i>
22d. LOCATION (City, town, or county) <i>Liberty Center</i>		(State) <i>Ind.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Sons, Co.</i>		ADDRESS <i>4905 York Road</i>	24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>
			24b. REGISTRAR'S SIGNATURE <i>JAN 23 '59</i>

TO HOSPITAL OR The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANUFACTURED BY THE STATE OF HAWAII - CALIFORNIA

CERTIFICATE OF DATA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00723

Reg. Dist. No.

731

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 126 Main St.				d. STREET ADDRESS 126 Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John		First	Middle	Last	4. DATE OF DEATH January 28 1959	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-1895	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. HOURS	13. MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Attd.		10b. KIND OF BUSINESS OR INDUSTRY Gasoline		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Walter Mc Cauley		14. MOTHER'S MAIDEN NAME Susan Allison							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WV1 216-10-4909		17. INFORMANT Mrs. Edith Mc Cauley, Ellicott City, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 hr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	Thomas F. Herbert, M.D.					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 1-28-59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-31-59	22c. NAME OF CEMETERY OR CREMATORIAL Good Shepherd		22d. LOCATION (City, town, or county) Ellicott City, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham		ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR DATE JAN 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Tracy				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE STATE OF MASSACHUSETTS
MASSACHUSETTS EXAMINER'S CERTIFICATE OF DEATH

DEATH

DEATH CERTIFICATE

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Filing 237 1-12-59 et
732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel rural		d. STREET ADDRESS Rt. 1 Box 24		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 1 Box 24				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) DENNIS MOORE		First	Middle	Last	4. DATE OF DEATH Jan. 3, 1959	Month	Day	Year 19
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug 1879	9. AGE (In years last birthday) 79 7/8 yrs.	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS. Days 1	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm Laborer		11. BIRTHPLACE (State or foreign country) Laurel, Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Dennis Moore		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Thos. Snell		Address Laurel, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral Gastro enteritis INTERVAL BETWEEN ONSET AND DEATH acute DUE TO 571.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Donald E. Fisher</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		(Columbia Pike Ellicott City)		
EXAMINER'S NAME (Type) Donald E. Fisher		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-3-59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/59		22c. NAME OF CEMETERY OR CREMATORIAL Beacons Chapel		22d. LOCATION (City, town, or county) Laurel (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE R. Selby		ADDRESS Laural, Md.		24a. REC'D BY REGISTRAR DATE 1-7-59		24b. REGISTRAR'S SIGNATURE Author of the		

DISCLOSURE		EXEMPTION		DATE ISSUED	
<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
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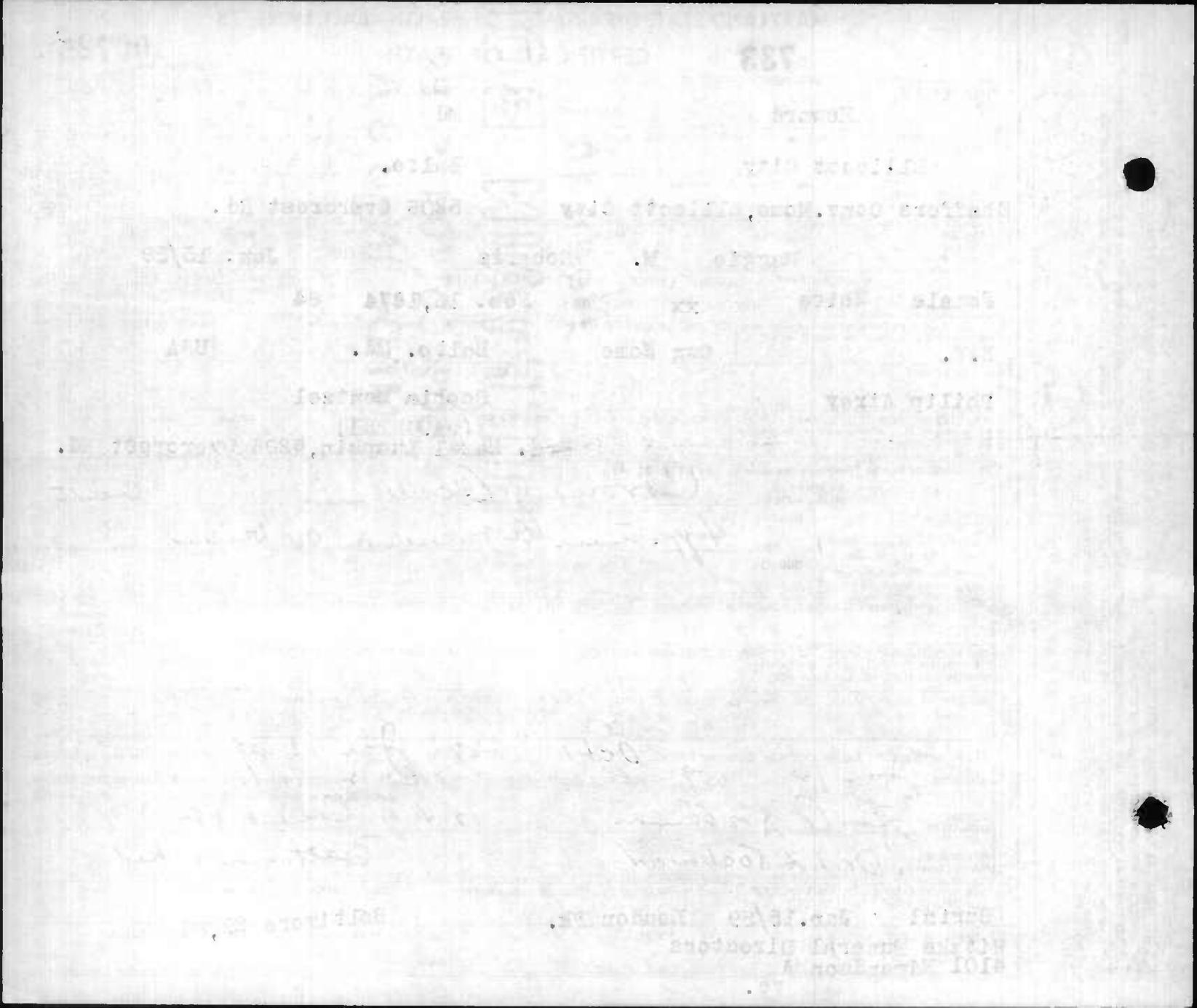
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

733 CERTIFICATE OF DEATH

Reg. Dist. No. 00725

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. (7)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Conv. Home, Ellicott City		d. STREET ADDRESS 5206 Overcrest Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Maggie	Middle M.	Last Roberts	
4. DATE OF DEATH	Month Jan.	Day 13/59	Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1874	
9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR Months 84	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
13. IF UNDER 24 HRS. Min. 0	14. BIRTHPLACE (State or foreign country) Balto. Md.	15. CITIZEN OF WHAT COUNTRY? USA		
16. FATHER'S NAME Philip Airey	17. MOTHER'S MAIDEN NAME Sophia Mentzel	18. INFORMANT (DAUGHTER) Mrs. Hazel Lumpkin, 5206 Overcrest Rd.	Address	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Chronic
		Coronary Occlusion Hypertriglyceridemia CV Disease		?
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
23. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
25. TIME OF INJURY Hour o. m. p. m.		26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)		
29. I certify that I attended the deceased from Oct. 1, 1958 , to Jan. 13, 1959 , that I last saw the deceased alive on Jan. 12, 1959 , and that death occurred at 2414 A. Cobet St. M., from the causes and on the date stated above. ACTUAL SIGNATURE Leon A. Kochman PHYSICIAN'S NAME (Type) Dr. L. A. Kochman		ADDRESS (Street, city or town, state) Baltimore 2-464		
30. BURIAL, CREMATION, REMOVAL (Specify) Burial		31. DATE THEREOF Jan. 15/59		
32. NAME OF CEMETERY OR CREMATORIUM Loudon Pk.		33. LOCATION (City, town, or county) (State) Baltimore 29-110		
34. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors		35. ADDRESS 4101 Edmondson A		
36. REC'D BY REGISTRAR DATE JAN 19 '59		37. REGISTRAR'S SIGNATURE Leon A. Kochman		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 3		e. STREET ADDRESS R.F.D. # 3	
3. NAME OF DECEASED (Type or print) Edna		First Marie	Middle Smith
4. DATE OF DEATH Jan. 22		Month 19	Day 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jonathan E. Moxley	
14. MOTHER'S MAIDEN NAME Mary O'Sullivan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Willard R. Smith, Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 210A.M.
20f. (City or town) Damascus, Md.		(County) (State)	
21. I certify that I attended the deceased from February 10, 1955 , to January 23, 1959 , that I last saw the deceased alive on January 21, 1959 , and that death occurred at 2:10A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James P. Kerr</i>		ADDRESS (Street, city or town, state) 112259	
PHYSICIAN'S NAME (Type) James P. Kerr, M.D.		DATE SIGNED 112259	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 24, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Pine Grove
22d. LOCATION (City, town, or county) Mt. Airy, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Moleworth</i>		24a. REC'D BY REGISTRAR DATE JAN 27 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

735

CERTIFICATE OF DEATH

00727

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HOWARD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENWOOD		c. LENGTH OF STAY IN 1b 9 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NEW YEARS GIFT FARM		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENWOOD	
3. NAME OF DECEASED (Type or print) RODERICK		Middle DOWS	4. DATE OF DEATH Jan 4 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Wholesale plumbing supplies		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME RODERICK D. WATSON		14. MOTHER'S MAIDEN NAME ALICE DOWS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES		16. SOCIAL SECURITY NO. WW # 1 225-05-1858	
17. INFORMANT Mrs. Angela R. Watson, Glenwood, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO CORONARY ARTERY OCCLUSION (c)		INTERVAL BETWEEN ONSET AND DEATH 5 MIN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOVEMBER 2, 1957, to JANUARY 4, 1959, that I last saw the deceased alive on JANUARY 2, 1959, and that death occurred at 5:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>C. S. Whitaker, M. D.</i> M.D.			
PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D.			
CLARKSVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/7/59	
22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMHREY, INC.		ADDRESS SILVER SPRING, MD.	
Raymond D. Ziska		24a. REC'D BY REGISTRAR DATE JAN 7 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

736

CERTIFICATE OF DEATH

Reg. Dist. No.

00728

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural (Laurel)</i>		c. LENGTH OF STAY IN 1b <i>23 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edith</i>		First <i>Edith</i>	Middle <i>Helen</i>
4. DATE OF DEATH <i>January 9 1957</i>		Month <i>January</i>	Day <i>9</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 10 1906</i>
9. AGE (In years less birthday) <i>52 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>	
11. BIRTHPLACE (State or foreign country) <i>Beatowmille, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Curry</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Rodifer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>James M. Wheatley, Laurel Md</i>	
17. INFORMANT <i>James M. Wheatley, Laurel Md</i>		18. ADDRESS <i>James M. Wheatley, Laurel Md</i>	
19. INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>		20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>200.1</i>		Lymphosarcoma	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.</i>		3 yrs	
(b) DUE TO <i>Generalized - Metastasis</i>		2 yrs	
(c) Diseases <i>Amoebo</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pericardial Fibroplasia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1957</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/21 1957</i> to <i>1/9 1959</i> that I last saw the deceased alive on <i>1/9 1959</i> , and that death occurred at <i>5:45 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Laurel Md.</i>			
ACTUAL SIGNATURE <i>B. P. Warren M.D.</i>		DATE SIGNED <i>1/9/59</i>	
PHYSICIAN'S NAME (Type) <i>B. P. WARREN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>January 12 59</i>	
22c. NAME OF CEMETERY OR CEMATORIAL <i>Woodlawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Woodlawn</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Warren</i>		24a. REC'D BY REGISTRAR DATE JAN 16 '59	
ADDRESS <i>Arthur S. Warren</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Warren</i>	

